		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: Embassy Care Center, Inc.

Address: 555 Kahler Road
Number City Zip Code

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 2/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		X	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Bob Kagda, Partner
(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd., 3750 W. Devon Ave., Lincolnwood, Il 60712-1124
(Telephone) (847)675-3585 Fax # (847)675 5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	101		955	1,056	8
9	SNF/PED					9
10	ICF	28,111	10,004		38,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,212	10,004	955	39,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.76%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 906

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	200,027	17,017	8,080	225,124		225,124		225,124			1
2	Food Purchase		172,248		172,248	(21,024)	151,224	(437)	150,787			2
3	Housekeeping	149,121	33,860		182,981		182,981		182,981			3
4	Laundry	41,288	9,012		50,300		50,300		50,300			4
5	Heat and Other Utilities			101,683	101,683		101,683	2,816	104,499			5
6	Maintenance	44,680		37,913	82,593		82,593	6,007	88,600			6
7	Other (specify):*											7
8	**TOTAL General Services**	435,116	232,137	147,676	814,929	(21,024)	793,905	8,386	802,291			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,103,184	57,133	193,739	1,354,056		1,354,056	(2,579)	1,351,477			10
10a	Therapy	58,690	983	3,011	62,684		62,684		62,684			10a
11	Activities	87,223	7,175	945	95,343		95,343		95,343			11
12	Social Services	46,319		3,858	50,177		50,177		50,177			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,295,416	65,291	207,553	1,568,260		1,568,260	(2,579)	1,565,681			16
	C. General Administration											
17	Administrative	94,277		278,850	373,127		373,127	(239,010)	134,117			17
18	Directors Fees											18
19	Professional Services			81,787	81,787		81,787	(12,123)	69,664			19
20	Dues, Fees, Subscriptions & Promotions			20,449	20,449		20,449	(6,814)	13,635			20
21	Clerical & General Office Expenses	88,979	19,195	55,983	164,157		164,157	70,027	234,184			21
22	Employee Benefits & Payroll Taxes			313,744	313,744	21,024	334,768	10,164	344,932			22
23	Inservice Training & Education											23
24	Travel and Seminar			594	594		594		594			24
25	Other Admin. Staff Transportation			11,549	11,549		11,549	1,810	13,359			25
26	Insurance-Prop.Liab.Malpractice			157,966	157,966		157,966	2,767	160,733			26
27	Other (specify):*											27
28	**TOTAL General Administration**	183,256	19,195	920,922	1,123,373	21,024	1,144,397	(173,179)	971,218			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,913,788	316,623	1,276,151	3,506,562		3,506,562	(167,372)	3,339,190			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Embassy Care Center, Inc. #0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			38,119	38,119		38,119	140,165	178,284			30
31	Amortization of Pre-Op. & Org.							3,882	3,882			31
32	Interest			48,540	48,540		48,540	512,806	561,346			32
33	Real Estate Taxes			64,635	64,635		64,635	2,834	67,469			33
34	Rent-Facility & Grounds			495,235	495,235		495,235	(495,235)				34
35	Rent-Equipment & Vehicles			150	150		150	3,816	3,966			35
36	Other (specify):*											36
37	**TOTAL Ownership**			646,679	646,679		646,679	168,268	814,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,122	9,857	53,979		53,979		53,979			39
40	Barber and Beauty Shops			1,338	1,338		1,338		1,338			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		44,122	104,818	148,940		148,940		148,940			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,913,788	360,745	2,027,648	4,302,181		4,302,181	896	4,303,077			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	54,982	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(437)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,777)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,353)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,466)	21		24
25	Fund Raising, Advertising and Promotional	(7,748)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,763)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,562)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	29,458		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 29,458		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 896		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Embassy Care Center, Inc.

ID# **0038711**

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ (2,347)	6	1
2	Deferred Maintenance	5,920	6	2
3	Marketing Salaries	(4,896)	21	3
4	Veteran Expenses	(2,579)	10	4
5	Non Care Expenses:			5
6	RE Tax	(3,454)	33	6
7	Interest	(9,060)	32	7
8	Depreciation	(3,846)	30	8
9	Embassy Bldg:			9
10	Trust Fees	(525)	21	10
11	Mortgage Costs	(5,630)	32	11
12	Adjust Real Estate Taxes to bill	(2,986)	33	12
13				13
14	**Frost, Ruttenberg & Rothblatt**	(9,360)	19	14
15	Krupnick, Bokor, Kagda & Brooks	(10,000)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(48,763)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(437)	0	0	0	0	0	0	0	0	0	0	(437)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,816	0	0	0	0	0	0	0	0	2,816	5
6	Maintenance	3,573	595	1,839	0	0	0	0	0	0	0	0	6,007	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,136	595	4,655	0	0	0	0	0	0	0	0	8,386	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,579)	0	0	0	0	0	0	0	0	0	0	(2,579)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,579)	0	0	0	0	0	0	0	0	0	0	(2,579)	16
	C. General Administration													
17	Administrative	0	0	(239,010)	0	0	0	0	0	0	0	0	(239,010)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,713)	0	8,590	0	0	0	0	0	0	0	0	(12,123)	19
20	Fees, Subscriptions & Promotions	(7,748)	0	934	0	0	0	0	0	0	0	0	(6,814)	20
21	Clerical & General Office Expenses	(30,664)	1,236	99,455	0	0	0	0	0	0	0	0	70,027	21
22	Employee Benefits & Payroll Taxes	0	0	10,164	0	0	0	0	0	0	0	0	10,164	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,810	0	0	0	0	0	0	0	0	1,810	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,767	0	0	0	0	0	0	0	0	2,767	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(59,125)	1,236	(115,290)	0	0	0	0	0	0	0	0	(173,179)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(58,568)	1,831	(110,635)	0	0	0	0	0	0	0	0	(167,372)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	51,136	78,862	10,167	0	0	0	0	0	0	0	0	140,165	30
31	Amortization of Pre-Op. & Org.	0	3,882	0	0	0	0	0	0	0	0	0	3,882	31
32	Interest	(14,690)	522,255	5,241	0	0	0	0	0	0	0	0	512,806	32
33	Real Estate Taxes	(6,440)	3,454	5,820	0	0	0	0	0	0	0	0	2,834	33
34	Rent-Facility & Grounds	0	(495,235)	0	0	0	0	0	0	0	0	0	(495,235)	34
35	Rent-Equipment & Vehicles	0	0	3,816	0	0	0	0	0	0	0	0	3,816	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	30,006	113,218	25,044	0	0	0	0	0	0	0	0	168,268	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,562)	115,049	(85,591)	0	0	0	0	0	0	0	0	896	45

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See schedule attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 495,235	Embassy Care Building Partnership		$	$ (495,235)	1
2	V	21	Bank Charges		Embassy Care Building Partnership		711	711	2
3	V	6	Repairs & Maintenance		Embassy Care Building Partnership		595	595	3
4	V	21	Trust Fees		Embassy Care Building Partnership		525	525	4
5	V	31	Loan Costs		Embassy Care Building Partnership		3,750	3,750	5
6	V	33	RE Tax		Embassy Care Building Partnership		3,454	3,454	6
7	V	30	Depreciation		Embassy Care Building Partnership		78,862	78,862	7
8	V	32	Amort Mtge Costs		Embassy Care Building Partnership		5,630	5,630	8
9	V	31	Amortization		Embassy Care Building Partnership		132	132	9
10	V	32	Interest		Embassy Care Building Partnership		516,625	516,625	10
11	V								11
12	V								12
13	V								13
14	Total			$ 495,235			$ 610,284	$ * 115,049	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 278,850	Future Associates	100.00%	$	$ (278,850)	15
16	V	5	Utilities		Future Associates	100.00%	2,816	2,816	16
17	V	6	Maintenance		Future Associates	100.00%	1,839	1,839	17
18	V	17	Administrative		Future Associates	100.00%	39,840	39,840	18
19	V	19	Professional Fees		Future Associates	100.00%	8,590	8,590	19
20	V	21	Clerical and General		Future Associates	100.00%	99,455	99,455	20
21	V	22	Employee Benefits		Future Associates	100.00%	10,164	10,164	21
22	V	25	Auto Expense		Future Associates	100.00%	1,810	1,810	22
23	V	26	Insurance Expense		Future Associates	100.00%	2,767	2,767	23
24	V	30	Depreciation		Future Associates	100.00%	10,167	10,167	24
25	V	32	Interest Expense		Future Associates	100.00%	5,241	5,241	25
26	V	33	Real Estate Taxes		Future Associates	100.00%	5,820	5,820	26
27	V	35	Equipment Rental		Future Associates	100.00%	3,816	3,816	27
28	V	20	License, Dues, Fees		Future Associates	100.00%	934	934	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 278,850			$ 193,259	$ * (85,591)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Haim Perlsdtein	Director	Administrative	22.96	See attached	24	40.00	Alloc Future	$ 39,840	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 39,840		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	991,241	4	$ 10,009	$	278,850	$ 2,816	1
2	6	Maintenance	Management Fees	991,241	4	6,537		278,850	1,839	2
3	17	Administrative	Direct allocation		4	149,601			39,840	3
4	19	Professional Fees	Management Fees	991,241	4	30,534		278,850	8,590	4
5	21	Clerical and General	Management Fees	991,241	4	353,538	253,435	278,850	99,455	5
6	22	Employee Benefits	Management Fees	991,241	4	36,129		278,850	10,164	6
7	25	Auto Expense	Management Fees	991,241	4	6,435		278,850	1,810	7
8	26	Insurance Expense	Management Fees	991,241	4	9,836		278,850	2,767	8
9	30	Depreciation	Management Fees	991,241	4	36,142		278,850	10,167	9
10	32	Interest Expense	Management Fees	991,241	4	18,631		278,850	5,241	10
11	33	Real Estate Taxes	Management Fees	991,241	4	20,687		278,850	5,820	11
12	35	Equipment Rental	Management Fees	991,241	4	13,564		278,850	3,816	12
13	20	License, Dues, Fees	Management Fees	991,241	4	3,321		278,850	934	13
14	21	Clerical and General	Direct allocation		4	43,880	43,880			14
15	22	Employee Benefits	Direct allocation		4	3,483				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 742,327	$ 297,315		$ 193,259	25

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$		9.7500	$ 453,068	1
2	Hawthorn Bank		X	Working Capital						Various	54,497	2
3	Minolta		X	Capital Lease - Equip	$1,066.00	12/31/99	21,285			18.3620	1,986	3
4												4
5												5
	Working Capital											
6	CIB Bank		X	Working Capital		12/99		480,590		Various	35,582	6
7	Provider License Fee		X								1,181	7
8	Insurance Financing		X								9,791	8
9	TOTAL Facility Related				$44,286.44		$ 4,531,285	$ 480,590			$ 556,105	9
	B. Non-Facility Related*											
10	Success National Bank		X	Mortgage - Non Care	$933.00	4/1/96	120,000			8.6250	9,060	10
11	Adjusment										(9,060)	11
12	Allocation from Future										5,241	12
13												13
14	TOTAL Non-Facility Related				$933.00		$ 120,000	$			$ 5,241	14
15	TOTALS (line 9+line14)						$ 4,651,285	$ 480,590			$ 561,346	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	109,781	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	117,278	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,497	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(28)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	67,469	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	51,707	8
	1997	53,199	9
	1998	53,454	10
	1999	54,781	11
	2000	56,677	12

Paid in 2001: 1999 bill of 54,781 and 2000 bill of 56677

Estimate based on 2000 bill adjusted to 60,000

Allocation from Future 5820

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Care Center, Inc. COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010	Nursing home	$ 56,677.00	$ 56,677.00
2.	10-28-408-025	Managemnet office	$ 19,875.47	$ 1,588.00
3.	10-28-408-026	Managemnet office	$ 9,729.67	$ 778.00
4.	10-28-408-027	Managemnet office	$ 9,729.67	$ 778.00
5.	10-28-408-028	Managemnet office	$ 14,207.15	$ 1,135.00
6.	10-28-408-029	Managemnet office	$ 14,207.15	$ 1,135.00
7.	10-28-408-030	Managemnet office	$ 1,536.56	$ 123.00
8.	10-28-408-031	Managemnet office	$ 1,535.56	$ 123.00
9.			$	$
10.			$	$
		TOTALS	$ 127,498.23	$ 62,337.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,635
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 3,882
4. Dates Incurred: 94,95,2000

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1993		$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 602,000	4
5											5
6	Alloc LCF		1986		61,137	2,568	30	2,038	(530)	30,738	6
7	Alloc LCF		1987		1,467	47	31.5	47		675	7
8											8
	Improvement Type**										
9	Various			1993	55,674	1,096	20	2,784	1,688	23,561	9
10	Various			1994	144,492	2,935	20	7,227	4,292	54,473	10
11	Various			1995	126,250	3,222	20	6,316	3,094	40,820	11
12	TILES FLOORING			1996	3,089	79	20	154	75	924	12
13	BATHROOM REFURBISHED			1996	5,800	149	20	290	141	1,692	13
14	DOOR ALARM			1996	1,441	37	20	72	35	420	14
15	ROOFTOP UNIT E WING			1996	16,485	423	20	824	401	4,738	15
16	EXHAUST FANS VESTIBL			1996	3,200	82	20	160	78	920	16
17	ELECTRICAL WIRING			1996	1,584	41	20	79	38	454	17
18	GAS LINE REPAIRS			1996	702	18	20	35	17	201	18
19	A/C REPAIRS			1996	693	18	20	35	17	201	19
20	A/C HEATING REPAIRS			1996	997	26	20	50	24	288	20
21	TILE FLOORING			1996	913	23	20	46	23	265	21
22	REFINISH PARKING LOT			1996	13,900	356	20	695	339	3,880	22
23	EVAPORATOR INSTALLED			1996	1,192	31	20	60	29	335	23
24	ROOFTOP CORRIDOR			1996	5,285	136	20	264	128	1,452	24
25	BUILD COPIER ROOM			1996	10,000	256	20	500	244	2,750	25
26	PAINTING DECORATING			1996	1,444	37	20	72	35	396	26
27	WIRING			1996	540	14	20	27	13	149	27
28	BUILTIN CABINETS			1996	6,500	167	20	325	158	1,788	28
29	WIRING NURSES STATIO			1996	5,780	148	20	289	141	1,565	29
30	SMITTYS			1996	577	15	20	29	14	157	30
31	HANDRAILS			1996	1,058	27	20	53	26	283	31
32	CARPETING			1996	752	19	20	38	19	203	32
33	WIRING			1996	646	17	20	32	15	171	33
34	2 5 ton air cond			1996	11,140	286	20	557	271	2,831	34
35	SIDEWALL GRILLS			1996	740	19	20	37	18	188	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SECURITY CAMERA	1996	$ 1,156	$ 30	20	$ 58	$ 28	$ 285	37
38	ROOFTOP A/C UNIT	1997	6,145	158	20	307	149	1,509	38
39	ROOF COATING	1997	1,010	26	20	51	25	251	39
40	FIRE ALARM SERVICE	1997	915	23	20	46	23	222	40
41	ROOF COATING	1997	1,250	32	20	63	31	305	41
42	PLUMBING-VALVE	1997	2,035	52	20	102	50	485	42
43	PLUMBING-VALVE	1997	627	16	20	31	15	140	43
44	PLUMBING-PARTS	1997	836	21	20	42	21	189	44
45	BOTTLES,CO2	1997	575		20	29	29	116	45
46	Floor Drain	1998	1,629	42	20	81	39	317	46
47	MOTOR	1998	976		20	49	49	180	47
48	POLE CONTRACTORS	1998	589		20	29	29	99	48
49	CIRCUIT BREAKER	1998	634		20	32	32	107	49
50	KEYPAD	1998	592		20	30	30	100	50
51	Electrc Outlets	1998	634	16	20	32	16	107	51
52	Alarm System	1998	592	15	20	30	15	100	52
53	Firelite panel	1998	1,551	40	20	78	38	254	53
54	New doors	1998	1,999	51	20	100	49	325	54
55	HVAC	1998	711		20	36	36	117	55
56	CIRCUIT BOARD	1998	559		20	28	28	89	56
57	DEFROST CLOCK	1998	519		20	26	26	82	57
58	Electrical lines	1998	2,134	55	20	107	52	339	58
59	Shower Faucets	1998	1,717	44	20	86	42	258	59
60	Floor Water Leak	1999	1,175	30	20	59	29	177	60
61	Fire Alarm Door	1999	711	18	20	36	18	102	61
62	New Cable For PA Sys	1999	624	16	20	31	15	88	62
63	Rear Door Alarm	1999	876	22	20	44	22	125	63
64	Fire Alarm Cables	1999	887	23	20	44	21	125	64
65	Couplings, Mounts	1999	526	13	20	26	13	72	65
66	Wood Door	1999	932	24	20	47	23	125	66
67	Heat sensors	1999	1,523	39	20	76	37	196	67
68	Heat Detectors	1999	650	17	20	33	16	80	68
69	Outlets and Cable	1999	825	21	20	41	20	96	69
70	**TOTAL (lines 4 thru 69)**		$ 2,884,592	$ 88,152		$ 92,559	$ 4,407	$ 785,680	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,884,592	$ 88,152		$ 92,559	$ 4,407	$ 785,680	1
2	Nurse call system	1999	634	16	20	32	16	75	2
3	Cable, Outlets - DON	1999	557	14	20	28	14	65	3
4	Window Glass	1999	645	17	20	32	15	75	4
5	New Drain Pipe	1999	3,000	77	20	150	73	338	5
6	Carrier Board	1999	668	17	20	33	16	72	6
7	Water Main	1999	683	18	20	34	16	74	7
8	Rep. 2.5 WaterMain"	1999	2,200	56	20	110	54	238	8
9	Fire Alarm System	1999	1,220	31	20	61	30	132	9
10	Extend PA System	1999	1,381	35	20	69	34	150	10
11	Door Lock System	1999	1,463	38	20	73	35	158	11
12	Roof Top Units	1999	553	14	20	28	14	58	12
13	Alarm System	1999	721	18	20	36	18	75	13
14	Boiler	1999	5,455	140	20	273	133	569	14
15	Clean floors	2000	872	22	20	87	65	145	15
16	100 A 240 V 3 POLE	2000	809	21	20	40	19	63	16
17	Single stage furnace	2000	2,891	74	20	145	71	205	17
18	Hot water heater	2000	2,500	64	20	250	186	292	18
19	Nurse call system	2000	750	19	20	38	19	44	19
20	Install h/water htr	2000	850	22	20	43	21	50	20
21	New Grease Trap	2000	15,037	386	20	752	366	815	21
22	Alarm system	2001	1,691	20	20	43	23	43	22
23	Sewer rodding	2001	1,265	4	20	11	7	11	23
24	Wire Fire alarm sys	2001	756	2	20	6	4	6	24
25	CCTV service	2001	945	3	20	8	5	8	25
26	Painting & Decorating	2000	44,888		20	2,244	2,244	2,304	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,977,026	$ 89,280		$ 97,185	$ 7,905	$ 791,745	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,977,026	$ 89,280		$ 97,185	$ 7,905	$ 791,745	1
2									2
3	Allocation from LCF	1987	8,414	267	31.5	267		3,806	3
4	Allocation from LCF	1988	473	15	31.5	15		200	4
5	Allocation from LCF	1989	176	6	31.5	6		68	5
6	Allocation from LCF	1993	4,887	125	39	125		1,048	6
7	Allocation from LCF	1994	7,452	191	39	191		1,424	7
8	Allocation from LCF-Air Cond; Roof repairs	2001	2,075	26	39	26		26	8
9	Allocation from Future	1987	26,517	842	31.5	842		12,733	9
10	Allocation from Future	1994	7,756	105	Var	471	366	3,711	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,034,776	$ 90,857		$ 99,128	$ 8,271	$ 814,761	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 739,882	$ 27,883	$ 73,579	$ 45,696	10	$ 534,026	71
72	Current Year Purchases	19,815	2,042	804	(1,238)	10	804	72
73	Fully Depreciated Assets	34,020	252	7	(245)		34,020	73
74								74
75	TOTALS	$ 793,717	$ 30,177	$ 74,390	$ 44,213		$ 568,850	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	1993 Ford Bus	1998	$ 1,200	$ 138	$ 138	$	5	$ 992	76
77	Alloc from Future			41,079	2,131	4,629	2,498		17,276	77
78										78
79										79
80	TOTALS			$ 42,279	$ 2,269	$ 4,767	$ 2,498		$ 18,268	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,015,772	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,285	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 54,982	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,401,879	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 150 Description: End loader
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 3,816	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,816	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 157	$		$ 157	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,075			9,075	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			625			625	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				28,853		28,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Supplies	39-2					15,269		15,269	13
14	TOTAL			$		$ 9,857	$ 44,122		$ 53,979	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 514,695	$ 516,309	1
2	Cash-Patient Deposits	62,040	62,040	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,000)	751,251	765,866	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,227	140,227	6
7	Other Prepaid Expenses	1,175	1,175	7
8	Accounts Receivable (owners or related parties)	167,534	1,573,376	8
9	Other(specify): Taxes	34,591	42,612	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,671,513	$ 3,101,605	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		145,000	13
14	Buildings, at Historical Cost		2,513,000	14
15	Leasehold Improvements, at Historical Cost	458,162	458,162	15
16	Equipment, at Historical Cost	340,444	732,444	16
17	Accumulated Depreciation (book methods)	(355,487)	(1,435,208)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Mtge Costs		101,346	22
23	Other(specify): Utility Deposit	3,478	3,478	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 446,597	$ 2,518,222	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,118,110	$ 5,619,827	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,421,931	$ 1,444,004	26
27	Officer's Accounts Payable	1,190,649		27
28	Accounts Payable-Patient Deposits	6,020	6,020	28
29	Short-Term Notes Payable	480,590	1,053,590	29
30	Accrued Salaries Payable	211,323	211,323	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,679	32,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	63,500	32
33	Accrued Interest Payable	2,691	42,131	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Capital Lease Obligation	2,086	2,086	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,407,969	$ 2,855,333	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,477,210	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,477,210	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,407,969	$ 7,332,543	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,289,859)	$ (1,712,716)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,118,110	$ 5,619,827	48

***(See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (980,548)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (980,548)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(309,311)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (309,311)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,289,859)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,952,264	1
2	Discounts and Allowances for all Levels	(133,830)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,818,434	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,625	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 88,625	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	147	12
13	Barber and Beauty Care	1,359	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,761	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	36,833	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 80,100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior period Adj	5,711	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,711	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,992,870	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	814,929	31
32	Health Care	1,568,260	32
33	General Administration	1,123,373	33
	B. Capital Expense		
34	Ownership	646,679	34
	C. Ancillary Expense		
35	Special Cost Centers	55,317	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,302,181	40
41	**Income before Income Taxes (line 30 minus line 40)****	(309,311)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (309,311)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,116	2,323	$ 49,554	$ 21.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,148	8,822	166,386	18.86	3
4	Licensed Practical Nurses	19,854	21,267	356,441	16.76	4
5	Nurse Aides & Orderlies	51,185	55,005	530,803	9.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,183	5,283	58,690	11.11	8
9	Activity Director	4,221	5,705	39,877	6.99	9
10	Activity Assistants	6,844	7,077	47,346	6.69	10
11	Social Service Workers	4,432	5,029	46,319	9.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,121	25,677	200,027	7.79	15
16	Dishwashers					16
17	Maintenance Workers	3,948	4,317	44,680	10.35	17
18	Housekeepers	21,097	22,358	149,127	6.67	18
19	Laundry	5,604	6,117	41,288	6.75	19
20	Administrator	2,086	2,139	55,646	26.01	20
21	Assistant Administrator	2,099	2,297	38,631	16.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,449	9,479	84,083	8.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	559	559	4,890	8.75	33
34	TOTAL (lines 1 - 33)	167,946	183,454	$ 1,913,788 *	$ 10.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 8,080	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant	6	828	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	10-3	39
40	Physical Therapy Consultant	96	874	10a-3	40
41	Occupational Therapy Consultant	55	2,137	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	945	11-3	44
45	Social Service Consultant	73	3,858	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	453	$ 24,522		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,662	90,515	10-3	51
52	Nurse Aides	4,404	100,596	10-3	52
53	TOTAL (lines 50 - 52)	7,066	$ 191,111		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Bersted	Administrator		$ 55,646
Kim Forrest	Asst admin		38,631
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,277

B. Administrative - Other

Description	Amount
Future Associates	$ 278,850
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 278,850

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Acctg	$ 45,840
Sachnoff & Weaver	Legal	3,516
Personnel Planners	UC cons	722
Various	Data Processing	9,696
Kpupnick, Bokor, Kagda	Acctg	21,000
Leland Cohn	Acctg	1,013
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 81,787

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,497
Unemployment Compensation Insurance	12,626
FICA Taxes	146,326
Employee Health Insurance	116,457
Employee Meals	21,024
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,006
Holiday Expense	832
Allocation from Future	10,164
TOTAL (agree to Schedule V, line 22, col.8)	$ 344,932

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,746
Health Care Worker Background Check (Indicate # of checks performed)	
Advertising	7,748
Dues & Subscriptions	9,006
License	949
Allocation from Future	934
Less: Public Relations Expense	( )
Non-allowable advertising	(7,748)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,635

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	594
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 594

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	6/99	$ 16,586	3	$	$ 2,764	$ 5,529	$ 5,529	$ 2,764	$	$	$	$
2	Painting & Decorating	6/01	2,347	3				391	782	782	392		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 18,933		$	$ 2,764	$ 5,529	$ 5,920	$ 3,546	$ 782	$ 392	$	$

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il Council LTC 7709**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10-20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **538** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **93,623**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,024** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.